Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: JAMES WEISS, MD 3100 TIMMONS LANE STE 250 HOUSTON, TX 77027	MFDR Tracking #: M4-11-0010-01 DWC Clai Injured En
Respondent Name and Box #: SOUTHWESTERN BELL TELEPHONE LP Box #: 17	Date of Inj Employer Insurance

PART II: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position Summary in accordance with rule §133.307.

Amount in Dispute: $90.98

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A. Documentation. Attached hereto is the following information regarding this dispute: 1. Medical Dispute Resolution Request/Review ("DWC 60"); 2. Explanation of Benefits concerning the treatments at issue; 3. Payment screens; and 4. Medicare Fee Guidelines. Respondent is not providing additional copies of information previously sent to the Division. Should the Division desire additional copies of any information, Respondent will promptly obtain and provide such additional information upon notice of its necessity. B. Dispute. The DWC-60 from the Requestor lists the dispute as a fee reimbursement dispute. This dispute involves an EMG/NCV that has been paid. If these are not the disputes, then please contact the undersigned so that the Respondent and the undersigned are aware of any different issues in dispute and may prepare a proper response. Respondent reserves the right to add or supplement this response with additional information, if necessary. C. Argument. The attached EOB's and payment screens reflect that all CPT codes billed for the date of service 6/10/10 have been paid. It is unreasonable for Requestor to expect 100% of billed charges when Medicare Fee Guidelines set reimbursement rates for some services. In conclusion, Respondent has paid for the services at issue. No further reimbursement is owed."

PART IV: SUMMARY OF FINDINGS

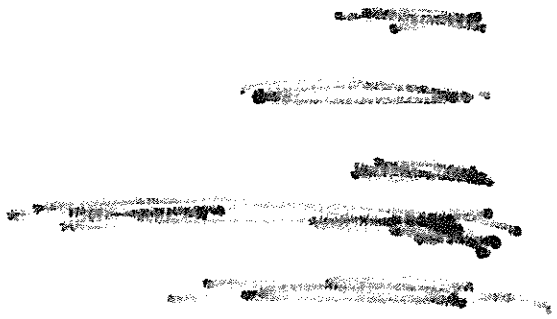
Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
6/10/10	95934	54.32 ÷ 36.8729 x $51.62 = $76.04	$65.98	$0.00
6/10/10	A4556	N/A	$25.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.



3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/30/2010

   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers compensation state fee schedule adjustment.

   Explanation of benefits dated 7/22/2010

   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the Respondent reimburse the Requestor per the medical fee guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule §134.203(c)(1)(2), To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor is to be applied. The conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. Commissioner's Bulletin #B-0048-09 states for services provided in calendar year 2010, the Medical Fee Guideline conversion factors in rule §134.203(c) are $54.32 and $68.19. The conversion factor of $54.32 applies to service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting. The Requestor billed CPT code 95934. The following is the MAR amount for this code and the reimbursement by the Respondent:

   95934 – MAR amount = $76.04. Requestor billed $142.02. Respondent paid $76.04. No additional is due.
2. The Requestor also billed HCPCS code A4556. Per NCCI edits, HCPCS code A4556 is bundled into payment of other services and is not separately reimbursable. Therefore, reimbursement for HCPCS code A4556 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		10/27/10

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.